Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 14, 2021	2021_838760_0011	025227-20, 004404-21, 005184-21	Critical Incident System

Licensee/Titulaire de permis

Southlake Residential Care Village
690 Grace Street Newmarket ON L3Y 8V7

Long-Term Care Home/Foyer de soins de longue durée

Southlake Residential Care Village
640 Grace Street Newmarket ON L3Y 8V7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 6, 7, 8, 9, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to an incident of resident to resident abuse;
A log was related to an allegation of staff to resident abuse;
A follow up log related to Compliance Order (CO) #001, O. Reg. 79/10 s. 73 (1), related to nutritional care, issued under inspection #2020_814501_0015, on December 14, 2020, with a compliance date of March 12, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with Behavioural Supports Ontario Manager (BSO Manager), Housekeepers, Environmental Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Associate Director of Care (ADOC) and the Interim Administrator.

During the course of the inspection, the inspector conducted observations and record reviews.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 73. (1)	CO #001	2020_814501_0015	760

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

According to Interim Administrator, public health had declared the home in an outbreak status, during the course of this inspection. A number of residents and staff had tested positive for the virus in the home's outbreak.

In addition, as per Directive #3, the home's visitor's policy must include providing strategies for supporting visitors in understanding and adhering to the home's visitor policy and to ensure that residents, staff & visitors are protected in the home from the risk of contracting the virus.

Observations were carried throughout the home during this inspection and noted the following:
- A PSW was seen without wearing any additional personal protective equipment (PPE) except for their surgical mask, while inside a resident's room. The ADOC stated that staff must always wear their eye protection and wear full PPE including a gown, while inside a resident's room.
- A person in the facility was observed to not have been wearing a face shield while inside a resident's room. The ADOC stated that everyone should be wearing their face shields when they are inside a resident's room.
- A housekeeper was seen inside a resident's room without wearing a gown. The housekeeper acknowledged they should have worn the appropriate PPE prior to entering the resident's room.
- An RN was seen wearing gown and gloves while walking in the hallway from the nursing station on a resident unit. The RN had stated they understood that gowns and gloves are worn only inside resident rooms but added their gown and gloves were "clean". The ADOC indicated there was no way to verify that the RN was wearing "clean"

PPE while they were in the hallway and thus, the RN should not have been in full PPE while in the hallways and the nursing station on the unit.
- A housekeeper was seen with a disposable gown inside the pocket of their scrubs. The housekeeper stated the gown was “clean” and did not know if this practice breached the home’s IPAC program. The ADOC indicated that this would not follow the home’s IPAC practices because the gown would be considered contaminated after it is placed in the pocket of the housekeeper’s scrubs. The ADOC added that gowns were readily available throughout the home and the housekeeper should have disposed the gown, if it was not being used.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and a person inside the home. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with an ADOC, two housekeepers, an RN and other staff; Observations made throughout the home during the inspector’s inspection. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that an intervention for a resident was followed in accordance to their plan of care.

A review of the progress notes had indicated that a resident was involved in an incident with another resident. A review of a resident's chart indicated they had an intervention in place to manage these incidents. An RPN indicated they did not provide the intervention following this incident. The BSO Manager indicated that interventions were put in place for these incidents that the resident becomes involved in and that it should have been provided by the RPN. There was potential risk to co-residents from this resident, as the failure to provide the intervention in their plan of care risks harm towards other co-residents.

Sources: Review of a resident's progress notes, plan of care and electronic chart; Interviews with an RPN, the BSO Manager and other staff. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was protected from physical abuse from another resident.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by a resident that causes physical injury or pain to another resident.”

A resident was seen with injuries by a PSW who was nearby. The staff overheard another resident who had stated they caused the injuries to that resident. The BSO Manager confirmed that this resident was physically abused by the co-resident, based on what was stated by the co-resident and the injuries noted. There was actual harm to this resident as they sustained an injury following this incident.

Sources: Two resident’s progress notes; Interview with the BSO Manager and other staff. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was treated with dignity and respect during the care they received from an agency PSW.

A review of the progress notes indicated that the resident had complained to a PSW that an agency PSW did not care for them properly. The resident demonstrated negative emotional responses after they had received the care from the agency PSW. An RPN added that the allegation from this resident was substantiated. There was actual emotional harm to the resident from the agency PSW, as the resident became emotionally upset following the care they had received from the agency PSW.

Sources: A resident's progress notes; Interviews with the resident, a PSW, an RPN and other staff. [s. 3. (1) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the names of all staff members involved in a resident abuse incident.

A Critical Incident System (CIS) report was submitted by the home related to an incident of abuse with a resident. A PSW had overheard the incident and responded to incident. BSO Manager confirmed that the PSW was not mentioned in the CIS report and that the names of all staff members should be in a CIS report.

Sources: Review of a CIS report; Interview with an RPN, the BSO Manager and other staff. [s. 107. (4)]

Issued on this 19th day of April, 2021

[redacted]

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JACK SHI (760)
Inspection No. / No de l’inspection :	2021_838760_0011
Log No. / No de registre :	025227-20, 004404-21, 005184-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 14, 2021
Licensee / Titulaire de permis :	Southlake Residential Care Village 690 Grace Street, Newmarket, ON, L3Y-8V7
LTC Home / Foyer de SLD :	Southlake Residential Care Village 640 Grace Street, Newmarket, ON, L3Y-8V7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Anne Deelstra

To Southlake Residential Care Village, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff and visitors are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

According to Interim Administrator, public health had declared the home in an outbreak status, during the course of this inspection. A number of residents and staff had tested positive for the virus in the home's outbreak.

In addition, as per Directive #3, the home's visitor's policy must include providing strategies for supporting visitors in understanding and adhering to the home's visitor policy and to ensure that residents, staff & visitors are protected in the home from the risk of contracting the virus.

Observations were carried throughout the home during this inspection and noted the following:
- A PSW was seen without wearing any additional personal protective equipment (PPE) except for their surgical mask, while inside a resident's room. The ADOC stated that staff must always wear their eye protection and wear full PPE

including a gown, while inside a resident's room.
- A person in the facility was observed to not have been wearing a face shield while inside a resident's room. The ADOC stated that everyone should be wearing their face shields when they are inside a resident's room.
- A housekeeper was seen inside a resident's room without wearing a gown. The housekeeper acknowledged they should have worn the appropriate PPE prior to entering the resident's room.
- An RN was seen wearing gown and gloves while walking in the hallway from the nursing station on a resident unit. The RN had stated they understood that gowns and gloves are worn only inside resident rooms but added their gown and gloves were "clean". The ADOC indicated there was no way to verify that the RN was wearing "clean" PPE while they were in the hallway and thus, the RN should not have been in full PPE while in the hallways and the nursing station on the unit.
- A housekeeper was seen with a disposable gown inside the pocket of their scrubs. The housekeeper stated the gown was "clean" and did not know if this practice breached the home's IPAC program. The ADOC indicated that this would not follow the home's IPAC practices because the gown would be considered contaminated after it is placed in the pocket of the housekeeper's scrubs. The ADOC added that gowns were readily available throughout the home and the housekeeper should have disposed the gown, if it was not being used.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and a person inside the home. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with an ADOC, two housekeepers, an RN and other staff; Observations made throughout the home during the inspector's inspection.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because the home was in an outbreak status during the inspector's inspection at the home. There was potential for possible transmission of infectious agents due to the staff and a

person in the facility participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: In the last 36 months, the licensee was found to be non compliant with s. 229 (4) of O. Reg 79/10, and three WNs, one VPC's, and one CO, were issued to the home. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 12, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

Service Area Office /
Bureau régional de services : Central East Service Area Office